19 December 2012

Expert Advisory Group

SHAPE OF TRAINING

5

To note

Update on Events and Emerging Trends and Issues

Issue

1. Update on review activities and a summary of emerging trends and issues that have been raised through our engagement work.

Recommendation

2. To note the emerging trends from the various review activities to date (paragraphs 9 – 20).

Further information

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Background

4. At the EAG meeting on 17 July 2012 members approved the communication and engagement plan for the review, which included hosting a variety of seminars, site visits, trainee and patient engagement events, as well as commissioning research and producing an open call for ideas and evidence.

5. Stakeholders have welcomed this review and are engaging fully in all activities. This paper identifies trends in the views expressed by those who have taken part in the various review activities. It also highlights the next steps in gathering evidence for the review.

6. We have already conducted the following site visits: Altnagelvin Area Hospital in Northern Ireland on 11 October 2012 and Musgrove Park Hospital in Taunton on 22 November 2012.

7. There have also been three seminars; Cardiff on 15 November 2012, London on 7 December 2012 and Edinburgh on 10 December 2012.

8. We have so far received 91 responses to the call for ideas and evidence. However, these are not captured in the summary of trends provided below.

Discussion

Emerging trends

9. The following paragraphs report on the key themes that have emerged from the events held so far. They do not, however, attempt to evaluate the merits or otherwise of the views expressed.

Flexibility

10. Stakeholders at various events are bringing the same issues to life around the different themes. It appears that the main concern surrounding the issue of flexibility is the need to have transferable competencies between different specialities. It has been suggested that the first year of speciality training should focus on acquiring more generic skills applicable to other disciplines. Although it was felt that this flexible, broad based approach to training might ultimately be attractive for employers in terms of having people with the right skills in the right jobs, the short-term effect might be a disruption to the service.

Changing perceptions of generalism

11. Some stakeholders have called for a cultural readjustment to the way specialists and generalists are perceived. The status of the generalist needs to be equal to that of the specialist. The importance of acknowledging the role of those

providing generalist care has been emphasised at all engagement activities. In order to encourage this cultural shift the role of the generalist needs to be attractive in terms of career development. Currently the way the training structure is designed, the end point is becoming a consultant, which if not achieved is seen as failure. Changing this view is possible if we create more than one legitimate end point and other career options, plus enhancing the role of the career grades.

12. Throughout various discussions, there has been keen interest in creating alternatives to the current training programme. One suggestion has been to train doctors up to a point where they can deliver a service, step out of training and focus on delivering that service for approximately one year and then return to further training. There have also been suggestions to encourage doctors to take time training abroad to widen their knowledge. There is a clear consensus that any change to the current training programme should include generalist training of approximately four to five years before entering a speciality. But many participants suggested generalists might need to train as long as or longer than some specialist training because of the breadth of learning and experiences needed to be a competent generalist.

Consultant present care

13. It has been highlighted in various discussions that a consultant presence is important for effective service delivery, which is supported by many trainees. There is sometimes a risk to patient care when a consultant is not on shift. The answer was not necessarily seen as 100% consultant delivered care, but the need to develop other supportive roles. It has been suggested that another level or cohort of doctors should be created, below the level of consultant. However, some have voiced concerns that this would be a tool for cutting the starting salary of consultants or devaluing the standards and quality of training given to doctors.

Meeting the needs of the community

14. Stakeholders have highlighted the importance of ensuring that all trainees are equipped with the skills to deal with common conditions affecting the community such as mental illness and dementia. At all events, people have suggested that doctors should have training experiences within all the different care contexts. Doctors would also benefit from training experiences that cut across their specialties and within different healthcare teams.

Working Time Regulations (WTR)

15. Many stakeholders have referred to the impact of the WTR on the delivery of healthcare and training. In particular, despite the desirable improvement in the work/life balance for trainees, we have been told that they are missing opportunities of valuable learning experience in terms of following patients through their entire care pathway. When trainees' required hours are fulfilled, they have to leave, even

though staying on would benefit the patient through continuity of care and would provide the trainee with valuable experiences following the patient's journey. The restriction on working hours has also left a number of trainees concerned their training is not long enough. The view has been expressed that because of the WTR doctors will lack the experience and training time necessary to be effective generalists, who are essential to providing healthcare in the future.

Length of training

16. Lastly stakeholders have commented on the length of medical training in the UK. They have drawn comparisons with systems in other countries where training programmes are much shorter than the UK. However it has also been noted that there are concerns in some specialities that training is not long enough.

Next steps

17. There are two more seminars planned: one in Manchester on the 8 January 2013 and one in Northern Ireland on 23 January 2013. Please let us know if you are interested in coming to either of these events.

18. There are six more site visits planned in January and February. They are in Nottingham, Birmingham, London, Cardiff, Edinburgh and North of Scotland.

19. We are now planning the oral evidence sessions that will follow on from the call for ideas and evidence. We are also planning a number of workshops in the spring for doctors in training, medical students, those involved in academic medicine, general practitioners, patients and employers.

20. The evidence collected from these events will feed into the final report.

> **Recommendation:** The group to note the emerging trends from the various review activities to date.

Resource implications

21. We are funding the various activities and events from the overall review budget. There is also a resource implication for the logistical planning and implementation of the engagement activities including time and support. This logistical support is provided jointly by the GMC and HEE.

Equality

22. We will make sure we engage with a wide range of organisations and individuals. We have begun to develop our approach to engage particular groups who have protected characteristics and who may be affected by potential reforms to

postgraduate medical education and training. We will discuss this further with the Expert Advisory Group as the review continues.

Communications

23. We will provide regular updates and information about the review on the website and in the Shape of Training newsletter. We will also publish the agenda, papers and minutes of the Expert Advisory Group.